Workforce Restructuring Plan

Department of Health and Human Services

November 9, 2001

Restructuring Principles

HHS's workforce restructuring plan is grounded on management principles intended to make HHS and its programs more responsive to the American people.

The first of these principles is a firm commitment to managing HHS as one department. One HHS means building a management culture that stresses accountability, cross-OPDIV collaboration, and citizen-centered customer service. The HHS restructuring plan shows how we will change that management culture and widen its vision.

Management accountability is a focus of "One HHS" and of our restructuring efforts. We are moving aggressively to implement the President's Management Agenda. We have set ambitious goals for reform and improvement in workforce planning and restructuring, budget and performance integration, financial accountability, information technology and e-government, competitive sourcing of commercial activities, and other business process and service delivery areas. We are implementing top-down performance contracts to support our emphasis on "One HHS" and management accountability. In addition, we are putting in place a system for monitoring restructuring progress and documenting accomplishments.

A third focus is on managing workforce restructuring and workforce transition. By implementing HHS-wide efforts in recruitment, retention, training, re-deployment and separation incentives, skills shortages and imbalances will not become a problem. Managing workforce change will allow us to deal with changing skills sets. This plan describes our initiatives and the human resources flexibilities that will allow us to manage change.

The concept of human capital is grounded on the premise that people add value to an organization through their work and their work products. In this view, people add value as capital, rather than being resources which are used up. Viewing employees as assets instead of resources has implications for how employees are treated. Assets are conserved, not used up or wasted. We conserve our human capital by providing meaningful work, by providing training and development so that employees have the skills they need, and by providing a supportive work environment. Strategic management of human capital cuts across HHS's internal organization and contributes to "One HHS."

The restructuring efforts in this plan relate directly to the workforce and skills assessment summary prepared in June 2001 in response to OMB's call. As such, the restructuring plan focuses on the strategic management of human capital. We should note, however,

that the strategic management of human capital, workforce restructuring, and the other elements of the President's Management Agenda are not merely inseparable but interwoven. E-government initiatives will change our workforce. HHS's Unified Financial Management System and Enterprise Human Resource and Payroll System will change the mix of skill sets our workforce will need. Establishing a unified approach to Information Technology in HHS will change skills sets. We have taken care to note these connections as we discuss human capital and workforce restructuring.

We must repeat that workforce restructuring is not a synonym for downsizing and FTE reduction. The Secretary is committed to every employee having a job. For employees with surplus skills restructuring may mean training, development, and re-deployment from support positions to mission-related functions. We may also need to offer voluntary separation incentives to those with surplus skills. For employees with shortage skills it will mean special efforts to keep them in our workforce. To offset the effects of retirements, resignations, and other attrition, we will focus on effective, coordinated recruiting of new employees with the skills we will need for the future.

Since restructuring does not mean downsizing, we have not calculated the budgetary impact of the first year of restructuring. Because organizational restructuring will drive much workforce restructuring, we must wait until we are closer to the event, or even until after restructuring is effected, to know the impact on the workforce.

We recognize that voluntary separation incentives ***may*** be needed to help reshape the workforce. As we consolidate administrative functions and re-deploy staff to more citizen-centered activities, we may reach a point at which we will need to provide buyouts for staff with surplus skills while recruiting new staff with shortage skills. This could come about when there are skills surpluses in administrative areas and there is a skills shortage in a professional area. In a case such as this, re-training is not feasible and voluntary separation incentives might be needed to facilitate workforce restructuring.

There are several key aspects to our potential use of voluntary separation incentives. Buyouts would be restricted to surplus skills sets in cases where re-training and re-deployment are not possible. Buyouts will be a last resort in re-shaping the workforce. We feel tight control of separation incentives is necessary, since experience shows that employees will put off retiring if they believe buyouts might be in the offing.

We see separation incentives taking the form of a cash buyout. However, we see buyouts as a means of re-shaping the workforce, not as a means of downsizing. Consequently, if we find ourselves needing to use buyouts we would also request that there be no accompanying FTE offset.

The Secretary's Restructuring Decisions

The Secretary reviewed restructuring proposals and made decisions on a series of cross-cutting activities:

- Consolidation of personnel offices:
  AHRQ and SAMHSA into the office already serving OS, ACF & PSC (FY 02)
  27 NIH personnel offices consolidated into one (FY 02)
  6 FDA offices into one (FY 02)
  HRSA into consolidated office with OS, ACF, *et al.* (FY 03)
  Full Parklawn (Rockville) consolidation in FY 04 brings 40 personnel offices in FY 01 to four: Atlanta, Baltimore, Bethesda, and Rockville

- Consolidation of OS administrative functions, to be implemented in FY 02, with elimination of all STAFFDIV shadow operations by FY 03

- Restructuring of Intergovernmental Affairs regional offices by realigning grades of regional directors, sharing administrative support with Regional Health Administrators, and redeploying current support staff within the same region (FY 02)

- Development of an HHS-wide intern program and consolidation of intern recruiting (FY 02)

- Development of an HHS-wide strategy for recruitment, retention and redeployment (FY 02)

- Deployment of core human resources functions of the Enterprise Human Resources and Payroll (EHRP) system beginning in FY02

- Consolidation of administrative functions at the OPDIV level (budget, IT, procurement, grants, finance), and across OPDIVs where feasible, with the clear direction that OPDIVs will not create or maintain shadow operations that duplicate functions performed on a consolidated basis (FY 03)

- Execution of an HHS-wide plan for consolidated Information Technology purchases (FY 02)

- Implementation of unified financial management system (FY 05/06)

- Examine payroll options EHRP, outsourcing (FY 04)

Departmental Restructuring Initiatives

Three cross-cutting restructuring initiatives are aimed at better aligning our workforce to mission, goals, and organizational objectives. All the HHS OPDIVs and STAFFDIVs are expected to develop internal actions which support the Department-wide initiatives, as well as fully supporting these cross-cutting initiatives.

De-layering

To move the Department to a more citizen-centered focus, OPDIVs have been directed to develop plans for reducing management layers in their organizations. We are now looking at making this initiative much more specific by mandating OPDIVs to restructure so that they have no more than four layers any place in the organization. HHS expects the OPDIVs to have developed concrete plans to meet this goal by November 30.

In considering how best to de-layer the HHS structure, we have spent considerable time reviewing organizations, discussing structure with key managers, and looking to understand why organizations are structured as they are. Managers across the Department generally feel that their structure and management layers are appropriate for mission accomplishment. Where OPDIVs have proposed structural changes they have generally been limited in scope.

Establishing a standard of no more than four management layers is a means of pressing all OPDIVs to seriously examine their structure and to de-layer. We discussed this standard with a sample of key managers in the OPDIVs before setting it forth as a Departmental goal. Managers felt that reducing to four management layers will be a challenge, as we intended it to be.

Administrative consolidation

OPDIVs have been directed to examine how they provide internal administrative services, and how they can consolidate those functions to achieve cost savings, economies of scale, and allow staff to be deployed to more mission-related functions. Specific OPDIV plans for meeting these objectives will be in place by November 30.

In line with the President's Management Agenda, we have developed plans to reduce duplication of effort, particularly in administrative management functions, reduce the number of management layers, and increase the speed of decision-making. At the same time, we have made a commitment that no employee will lose a job as a result of these streamlining efforts. Implementation of these plans will provide opportunities for redeploying staff to core mission and service delivery positions. They are not intended to produce FTE savings or reductions.

Consolidating Personnel Offices

A major consolidation effort involves the Department's personnel offices. Under decentralized management practices, most Operating Divisions have staffed a separate personnel office. This has led to the situation of having seven different personnel offices in one building and each of NIH's Institutes and Centers having its own personnel office. Consolidation will significantly reduce this duplication.

- By the end of FY 2003, we will reduce the number of personnel offices in HHS from the current 40 to 6. This will include cross-OPDIV consolidation of AHRQ, SAMHSA, and HRSA personnel offices with an existing cross-servicing personnel office, as well as OPDIV-level centralization at NIH and FDA (from 27 offices to one and six to one, respectively).

- In FY 2004 consolidation will reduce the number of personnel offices to four: Baltimore, Atlanta, Bethesda, and Rockville. This will provide on-site service for the major employment centers of the Department, take advantage of economies of scale, and allow us to re-deploy staff to program activities.

Consolidating Administrative Offices

In the Office of the Secretary, where each Staff Division has traditionally had its own administrative office, we have consolidated these separate offices to eliminate duplication and to provide the same level and quality of service more efficiently.

- Effective October 7, nine separate administrative offices in OS were consolidated into one. The consolidation brings together in one service provider grants, budget, financial management, procurement, and HR administration. The consolidation will allow us to redeploy about 20 staff from administrative support to program management activities.

In this consolidation the 64 staff in the nine former offices fell into three categories: those who moved to the OS Executive Office, those who continued in liaison functions in the STAFFDIVs, and those available for re-deployment in FY 2002. The liaison function in the STAFFDIVs is intended to assure smooth transition of services to the OS Executive Office. The transitional nature of the liaison function is underlined by the Secretary's explicit statement that this liaison function will be terminated in FY 2003 and the staff will be re-deployed. Documenting the elimination of the shadow function makes it an event that will be tracked to completion in the restructuring effort.

The Operating Divisions have been directed to take similar action and achieve administrative consolidation by 2003. Specific plans must be in place by November 30.

Our efforts to consolidate and better coordinate legislative and public affairs activities across the Department are still in the formative stages. HHS staff is working with the OPDIVs to develop new models for managing these functions across the Department.

The Secretary is keenly interested in improving performance in these areas. We expect decisions in how to restructure the legislative and public affairs functions in 2002 and we will provide information on those decisions as they are made.

On a broad scale, the efforts to restructure management, consolidate administrative functions, and develop new models for functional management in the legislative and public affairs areas are an essential part of building "One HHS." These cross-cutting efforts, combined with OPDIV initiatives to to delayer by eliminating deputy and other management positions, improving supervisory ratios and increasing span of control will change the way in which HHS operates and is managed.

Accountability

HHS is taking steps to improve management accountability and to ensure results from its restructuring plans, These efforts also support the Secretary's "One HHS" initiative by stressing cross-OPDIV efforts.

Performance Contracts

We are developing performance contracts for HHS's OPDIV and STAFFDIV heads, linking individual performance to the attainment of agency-specific and Department-wide goals. The inclusion of Department-wide goals moves the performance plans from the OPDIV/program arena to a wider focus on cross-cutting efforts that contribute to "One HHS." The primary performance contracts cover the heads of the OPDIVs and STAFFDIVs. Building on these 20 performance contracts, operating and staff divisions will develop performance plans for each non-career SES and Schedule C staff member, then expand the coverage to the career SES positions. We will conduct workshops for HHS staff to train them on how to apply the performance contract templates that are being developed. This will assure uniformity of application, in accordance with the "One HHS" philosophy.

At the management levels, performance contracts will be required to include an element supporting the President's Management Agenda. This element will be tailored to reflect the individual's position, to assure that it is meaningful. Other key elements of the individual performance contracts are:

- *Outcome measures* – existing HHS performance measures for the "outcomes" covered by the program areas that are the responsibility of the official will be included in the contract.
- *Intermediate outcome measures* – HHS performance measures, as well as measures for the Administration's and the Secretary's policy objectives will be included if the official is substantially involved in the development and execution of initiatives in support of those policy objectives.

- *Program output measures* – HHS performance measures for specific activity levels to be achieved by the program areas led by the official will be included in the contract.
- *Key activity/process measures* – HHS performance measures, as well as unique performance measures covering process-oriented objectives will be included. These will include measures reflecting achievement of the President's Management Plan.

This process assures that performance expectations are aligned across HHS. This degree of cross-OPDIV alignment is a significant culture change. The perspective of managers is expected to be broader than their program, broader than their OPDIV. Their perspective is to be departmental in scope, encompassing "One HHS." The process also provides greater accountability for the Department's senior managers, an accountability which will extend downward to all levels of the Department. The accountability demanded by performance contracts that contain clear performance expectations and measures will extend beyond the senior managers to all levels of HHS.

Performance contracts in a system that includes all levels of HHS also provides an objective means for differentiating between high and low performers and providing appropriate incentives, awards, and recognition.

OPDIV and STAFFDIV head contracts are scheduled to be finalized in November. On November 9 the first training session for HHS staff responsible for cascading contracts down to staff levels will be held. The process will bring staff employees under performance contracts in 2002.

Creating a Focus for Management

On October 3, 2001, HHS announced a major restructuring in the Office of the Secretary, realigning functions and establishing the position of Assistant Secretary for Administration and Management (ASAM). This move creates a single focus for management within the Department. Management improvement, accountability, and implementing the President's Management Agenda are the primary functions of the Assistant Secretary for Administration and Management. Secretary Thompson's memorandum announcing this realignment, along with a chart showing Departmental reporting relationships, is included with this report.

The budget, information technology and finance functions are now under the Assistant Secretary for Budget, Technology, and Finance. This maintains the close relationship between budget and finance and provides oversight for the Department's investments in information technology.

The focus of the ASAM will be departmental management, including human resource policy, grants management, acquisitions, and departmental operations. The ASAM will

have the lead for HHS's restructuring of administrative operations to make them more efficient and responsive. In addition, the Program Support Center (PSC) will report to the ASAM. This is intended to provide better coordination of administrative systems and departmental management activities. The ASAM will house the OS Executive Office, formed by consolidating nine separate administrative offices formerly located throughout the Office of the Secretary. Placing departmental management responsibility in the ASAM will provide better oversight and accountability for implementing management reforms.

Tracking Progress

HHS will track progress on its restructuring initiatives through a two-level process. The first is a work/progress matrix. This matrix will track completion of distinct steps in restructuring on three axes: time, initiative, and OPDIV. In this way we will be able to track when things are to be accomplished (**time**); what actions are being taken and will taken by all OPDIVs relating to each area (**initiative**); and to track each OPDIV's accomplishments on both cross-cutting initiatives and on internal actions (**OPDIV**). This system supports the cross-OPDIV nature of initiatives, but also provides greater OPDIV accountability for results. OPDIV plans will be in place November 30; their actions will be translated to the tracking system in December, and the first quarterly report will be due January 10, 2002, tracking accomplishments for the first quarter of FY 2002.

The second level of evaluation focuses on the alignment of human capital strategies with mission, goals, and objectives. Measurements here include the degree to which human capital strategies are:

1. Integrated into budget and strategic plans;
2. Consistent with OPM's Human Capital Balanced Scorecard (currently in draft form); and
3. Compliant with merit-based HR principles.

This second level is reflected in the OPDIVs development of objectives for their FY 2003 performance plans that directly and concretely support cross-cutting de-layering and administrative consolidation objectives. These will be included in the GPRA plans included with the FY 2003 Congressional justification.

Managing Human Capital

Managing the 21st-Century Workforce

Key challenges of managing human capital are developing and sustaining a a high-performing workforce; improving productivity; and strategically using existing personnel flexibilities, tools, and technology. Strategic workforce planning provides a means for aligning the workforce to meet these demands as well as looking forward to meet address impending changes in skills sets and transition issues through effective succession planning.

HHS's workforce and skills analysis summary discussed the impact of retirements and resignations on our workforce in the next five years. By the end of fiscal year 2005 nearly 19,000 of our current employees reach retirement eligibility. We project that by the end of FY 2003 about 3,900 employees will opt to retire and that another 3,350 will retire in FY 2004 and 2005.

In FY 2000 resignations accounted for 51 percent of our losses of permanent employees. By contrast, retirements were 31 percent of permanent losses. Resignations pose at least as great a problem to workforce planning as retirements. We are taking several steps to respond to projected retirements and ongoing losses through resignation.

Recruitment and Retention Strategy

The Department-wide recruitment and retention strategy is designed to meet our short and long term workforce needs. It includes mechanisms for recruiting professional, administrative and technical skills and competencies and diversity. The strategy includes action items to be accomplished through FY 05.

The strategy is designed to strengthen the Department's image on college campuses nationwide, tap into our internal potential, and build on student education and employment programs. It should enable us to rebuild the entry pipeline, enhance student employment programs, and create additional structures such as internships and fellowships. It significantly refocuses and reinvigorates entry-level recruitment. This revitalization includes an assessment of tools, initiatives and new techniques.

The objectives within the strategic plan include:

- Use workforce analysis data as a foundation for recruitment throughout the Department
- Recruit more effectively internally and externally
- Design and implement a targeted recruitment marketing campaign
- Partner with professional, educational and minority organizations
- Make student programs more productive recruitment tools

- Streamline the hiring process and give managers useful hiring tools
- Strengthen orientation, mentoring and career management tools
- Strengthen college relations programs
- Monitor and evaluate the Recruitment Strategy to assess results

This coordinated strategy will provide central guidance and leadership to our recruitment and retention efforts, foster the "One HHS" concept, minimize duplication of effort in recruiting, and increase cooperation among the component parts of HHS.

Career Intern Program

A Department-wide Career Intern Program is a vital component of the Recruitment and Retention Strategy. We will use this program to attract exceptional men and women to the Department who have diverse professional experiences, academic training and competencies, and prepare them for careers in analyzing and implementing health and social services programs. Through an aggressive recruitment effort, we will seek the highest caliber people for entry level positions, develop their professional abilities, expose them to all operating divisions through rotational assignments, set high expectations for self-learning and closely monitor their progress throughout a formal two year training period. While the internship will not guarantee conversion to a permanent position, we expect a significant placement rate and a great return on investment.

The Intern Program will be in place in FY 2002 with the first class on board by September, 2002. We are still making programmatic decisions on the structure and operation of the Career Intern Program. These decisions will affect costs and therefore impact calculation of return on investment. HHS budget and human resources staff are working together to refine cost estimates and will provide information on return on investment when reasonable estimates are available.

The Department-wide Intern Program is just one recruitment vehicle. HRSA's Scholars Program can and will continue. HHS, like other departments, faces a challenge in replacing senior-level staff as they retire. To offset retirements and other attrition, we must replenish the pipeline and provide a steady influx of new, talented staff. Given the magnitude of our projected retirements, and attrition, one program will not yield sufficient staff to offset losses. This is especially true when we consider the internship as a two-year training program at entry grade levels. There is room in the recruitment process for OPDIVs to manage programs such as the HRSA Scholars Program to help meet agency specific and/or unique skills needs.

Student Recruitment Initiative

Each year, the Department hires nearly 2,000 students through various school programs, fellowships, internships and summer appointments. Most of these students are successful in their short-term jobs with HHS and are good candidates for permanent jobs – employees who have experience with the Department and would like to return. Yet in the past we have allowed these potential future employees to finish their programs without actively recruiting them and engaging them for the future. We will begin to target current student employment as a prime recruiting source. The promising student who spends a semester or a summer with HHS will leave with assurances of the Department's interest in future hiring and knowing when and how to stay in touch.
We see this as a means of maximizing our recruiting efforts and targeting candidates with proven ability.

Recruitment and Retention Incentives

Within budget limitations, we will continue to use existing tools to address our recruiting and retention priorities. These include recruitment and relocation bonuses and retention allowances (the "3Rs"), Physician Comparability Allowances (PCA), and student loan repayment. HHS Operating Divisions have included in their FY 2003 budgets include$8.8 million for the "3Rs" and $15 million for PCA.

Efforts to improve retention go beyond the use of bonuses and depend on several key sets of data. Understanding why employees resign, or what drives them to leave is one element. On a Departmental scale some of this data is lacking. We believe that there is a good deal of information on this issue at the programmatic level, however, providing a sound basis for retention efforts.

The issue of why employees resign is only one side of the coin. The corollary question is what induces employees to stay. A complete retention program must deal with both what drives people to resign and what coaxes them to stay. We have some answers to both questions; enough answers that we feel confident that our retention plans will be effective. As we carry out our retention initiatives, we will be developing additional information both to assure that our efforts are on track and to refine and expand our efforts.

Training and Development

As part of both our retention and redeployment strategies, we are investing in training and development programs for employees to acquire new skills and to remain current in their fields. In FY 2001 we rolled out access to electronic training in HHS through the Distributed Learning Network (DL/net). In FY 2003 all HHS employees will have desktop access to HHS courses through DL/net and at least 20,000 employees will be able to select 1,200 courses provided by contractors. Total cost for this investment in FY 2003 is budgeted at $1.7 million.

This use of technology is extremely cost effective: A one-day course at a not-for-profit training institution typically costs $195; the annual cost of providing access to over 1,200 courses through DL/net is $44 per employee, a substantial savings.

The need for maintaining employee skill and knowledge levels has driven CDC and FDA to develop corporate "universities." These training initiatives are intended to help employees maintain state-of-the-art skills and to develop new skills that will be needed in the future. In rapidly evolving knowledge areas – such as the health field – knowledge can quickly become outdated. Providing the means for maintaining this knowledge base is an incentive in recruiting new employees and a means for helping to retain current staff.

Related Initiatives

Initiatives relating to other parts of the President's Management Agenda will impact on our workforce. E-government and information technology initiatives will change skills sets needed in our workforce. These initiatives include the new personnel system, unified financial management system, and the development of a system for electronic grants. These will change the way in which we carry out our business, and, in turn, affect the skills sets our employees will need. Competitive sourcing efforts will also affect skills sets as we change the way in which we do our business.

Enterprise Human Resources and Payroll System

We are applying technology to provide improved human resource services at lower cost. In FY 2002 we will begin the rollout of the Enterprise Human Resource / Payroll System to replace HHS's 30-year old legacy personnel and payroll system. The EHRP business case is attached. Implementation of the EHRP will greatly facilitate our personnel office consolidation initiative and result in significant savings, including:

- Estimated reduction of HR staff. Current HR staff is HHS is slightly over 1,000, for a servicing ratio of 1:63. We expect that the combination of personnel office consolidation and the EHRP will allow us to move our servicing ratio to 1:82 – a 30 percent increase. This translates to a reduction of human resources staff by about 250, based on current employment levels.

- Overall cost savings and cost avoidance due to streamlined business processes, lower maintenance costs and the need for fewer ancillary systems are estimated at $100 million against the system cost of $19 million.

- Initial cost savings from the EHRP will be offset by start-up costs. We expect that the cost savings will begin to accrue in FY 2004 as the EHRP is fully on-line, start-up training in the new system is completed, and we are able to re-deploy staff.

Unified Financial Management System

HHS is developing a Unified Financial Management System (UFMS) to replace five legacy systems. We will have one financial management system for CMS and the Medicare Contractors called the Health Care Integrated General Ledger and Accounting System (HIGLAS), and another financial management system for the rest of HHS. Both systems will feed into a unified Department reporting system. This initiative will vastly improve overall financial management, providing timely cost data on a programmatic basis for managers, budget staff and OMB. When finished, the UFMS will allow the Department to consolidate accounting operations into fewer offices. We expect this consolidation to provide additional savings through economies of scale, although it is too soon to identify the precise impact on the workforce.

Electronic Grants

HHS and OMB are leading the effort to implement the Federal Financial Assistance Management Improvement Act (P.L. 106-107). As the largest civilian grant-making Department, HHS is working with 26 other Federal agencies to streamline the grant process across the Federal government. The initial plan, delivered to Congress May 18, 2001, addresses streamlining grant application and reporting forms, and offering electronic options for conducting grant business. The plan includes the Federal Commons portal which will open as a single point for electronic grant information/ transactions in FY 2002, and which will be fully functional in FY 2003.

Internally, HHS is pursuing initiatives aimed at providing better grants and contracts services at reduced cost. Initiatives include:

- Consolidating and outsourcing grant-related clerical and administrative functions where possible;
- Streamlining the competitive grants application review process;
- Consolidating and accelerating the annual grant planning process throughout the Department;
- Placing a moratorium on the creation of new grants management offices, and new electronic grants management systems,
- Consolidating commercial indirect cost rate negotiation functions for grants, as well as contracts into one office, and
- Consolidating the purchasing of information technology commodities and services.

This increased use of information technology will change the way in which we manage grants and contracts, changing the skill set needed in this function. In addition, we expect that consolidating offices will allow us to benefit from economies of scale.

Conclusion

The initiatives presented here demonstrate HHS's commitment to implementing the President's Management Agenda. More detail on individual initiatives, cost savings, cost avoidance and staff re-deployment will be in the OPDIV restructuring plans, which are to be competed November 30.

The restructuring effort in many ways is a work in progress. We expect that we will find opportunities for restructuring that we can not see at this time. The aim of our management improvement efforts and our accompanying workforce restructuring is to strengthen management accountability and to provide the American public with the best possible service for their tax dollars. We believe that the efforts underway in HHS to implement the President's Management Agenda and to manage the Department as "One HHS" will achieve this goal.